Full agonist (methadone) For the treatment of opioid dependence
- For withdrawal and maintenance
- From a specialized, certified, and licensed methadone practice in an Opioid Treatment Program (OTP)
- Brand names: Methadone, Dolophine

Partial agonist (buprenorphine/BUP) For the treatment of opioid dependence
- For withdrawal or maintenance
- Available in tablets, sublingual films, buccal films, and now implant
- Can be prescribed by any DATA 2000 waivered physician, physician assistant, and nurse practitioner in any healthcare setting

Antagonist (Naltrexone oral-ReVia, Naltrexone ER IM-Vivitrol) For relapse prevention to opioid dependence, after being opioid free (including methadone and buprenorphine) for 7 to 14 days
- Can be prescribed by any physician, physician assistant, and nurse practitioner in any healthcare setting

Cited References:

Additional References:

Adapted from presentations by Jeff Watts, MD: The original presentation, Recipe Book for Medication-Assisted Treatment (MAT) Integration, can be found at: PCSS-MAT (the Providers’ Clinical Support System for Medication Assisted Treatment) http://www.attcnetwork.org/userfiles/file/GreatLakes/Webinars/2017%20Webinars/Watts%20Webinar%20Final.pdf
Clinical Space: No specific requirements for buprenorphine (BUP) or naltrexone/Vivitrol, but, here are some suggestions:

- Nearby bathroom for urine toxicology screens and gastrointestinal issues in opioid withdrawal
- Ideal to have 2 patient rooms so that prescriber (MD, DO, NP, PA) can be monitoring an induction while seeing other patients simultaneously
- Small conference room on weekly basis (if on-site medical treatment for OUD groups are provided)
- Note: No unusual emergency equipment is needed

Clinical Tools

- Screening and assessment tools: Clinical Opiate Withdrawal Scale (COWS) only requires phone/watch (for pulse) and pen light (for pupil dilation)
- Patient-centered educational materials (including overdose education and naloxone training), patient-provider agreement (if required by treatment agency)
- Other helpful documents—sample induction, notes/progress notes, policy/procedures, FAQs for covering physicians, billing information, protocol/algorithm, implementation checklist
- Prescription monitoring website/database

Pharmacy

- Most insurers have Suboxone, Zubsolv, and/or Bunavail on their formularies as well (varying prior authorization requirements)
- Immediate availability of BUP & naltrexone will dictate induction model
- Partnering with on-site or nearby pharmacy is helpful to, for example, ensure BUP and naltrexone are always stocked, arrange for daily (or more frequent) delivery services, coordinate invoicing agreements
- Naltrexone XR (Vivitrol) is being added to more formularies but prior authorization is often required. Can be expensive
- If stocking/storing Naltrexone XR, practice will need refrigerator

Toxicology Testing

- Urine vs. Saliva—ease of use, cost, detection window
- Send-out lab—know what is tested for
- Point of Care (POC) testing—likely need assay with high detection of opiates (e.g., 300 ng/dl) - need separate methadone, BUP, oxycodone, maybe fentanyl

Models of Induction/Care Delivery: Patient already inducted at another site. You need to evaluate the patient to see if they are on the correct dose or need an adjustment.

- Comes to your clinic already on medication 1,2
- From hospital ER or inpatient ward 3
- From correctional setting 4
- From induction center (hub-and-spoke model)
- From substance use treatment program

Made from Scratch: Initiate on-site assessment, induction, monitoring. (This approach can be difficult because stocking BUP requires a lot of paperwork for the medical practice. Most providers who take this approach have patients pick up BUP at a local pharmacy and bring it in for office induction. Vivitrol and naltrexone can be stocked—if Vivitrol is refrigerated).

- Traditional “made from scratch” model taught in waiver training 5
- Inductions are on-site and observed (using the COWS Instrument)
- Requires prep time (pre-assessment), space for extended period (on induction day), medication availability, and more staff time than the “Delivery” or “Out of a Box” models
- Ensures BUP and naltrexone are taken correctly and allows for direct monitoring of potential precipitated withdrawal 6

Out of the Box: Initiate on-site instructions with “home” non-observed induction for BUP. (This is the simplest process for the prescribing provider and the medical team).

- Patients are given a prescription and instructions—written, online, video—on when and how to take BUP or naltrexone
- Patients have to assess timing of their last use and severity of withdrawal before taking medication (Subjective Opiate Withdrawal Scale [SOWS] instrument)
- Does not require extended clinic visit or space occupation
- Does not require on-site medication 7
- A very good option in patients who have been previously prescribed (or otherwise have experience with) the treatment medication
- Screening tools are available to determine is patient is a good candidate for home induction

Making Changes for Next Time

- Administrative support staff keeps tracking log to know when prescriptions are due, most recent toxicology results, current schedule (weekly, biweekly, monthly), other tasks as needed
- Utilize quality improvement methods such as lunch-n-learns and e-consultations
- Anticipate / Plan for Common Issues
  - Urine toxicology positive for opiates, methadone, fentanyl
  - Urine toxicology negative for BUP (a problem when BUP is prescribed)
  - Urine toxicology repeatedly + for THC, benzodiazepines, cocaine, PCP, amphetamine
  - Patient seeking benzodiazepines or prescription opiates / tramadol
  - Lost/stolen prescriptions
  - Missed/appointments—policy around walk-ins
  - Patient seeking benzodiazepines

Serving the Food: Patient Flow / Scheduling

- Three phases of treatment—induction, stabilization, and maintenance
- After induction, a follow-up visit or call the next day is recommended. Consider role of team members to make these calls and document results.
- For example, at Dr. Watts’ clinic, (see Additional References) they provide:
  - A one-week prescription for 4-6 weeks
  - Two week prescription for the following 6-8 weeks, then
  - Monthly thereafter
  - Issues with lost prescriptions, diversion, problematic toxicology results, etc., resets the process
- As in cooking, medical treatment clinic flow and scheduling is often dictated by the shape in which it was prepared. Your management may differ based upon staffing, space, capacity, etc., within your clinic.